

Dear Katie,

Please find below the information requested to complete our in the process application.

1. **TRAUMA MEDICAL DIRECTOR**- St. Mary's Hospital is located in Waterbury, Connecticut.

2. **RESPONSE TIMES**- Effective July 1st we developed separate general surgery call schedules for each of our campuses. General surgeons taking call at the Northlake campus cover trauma. Also implemented at the same time was the 30 minute response time for our highest level-trauma activation. Prior to July 1st, there was one schedule and surgeons would cover both campuses.

Attached you will find documentation of our trauma activations and surgeon response times for the month of July. We recognize the response times are sub-optimal and have done the following to enforce compliance:

- a. Removed non-compliant surgeon from call schedule
- b. Outliers have been addressed with each individual surgeon and will be presented at our next Trauma Program Performance Improvement Committee on August 7th, 2014 and at each subsequent monthly meeting.
- c. Created an in-hospital call suite for surgeons taking call which became available for use on July 22nd.
- d. Response times will be vigilantly monitored on a daily basis.

3. **ORTHOPEDIC SURGERY**- Attached you will find the revised commitment letter.

4. **TRANSFER AGREEMENTS**- Please note the transfer agreement between Methodist Hospital and St. Joseph is for isolated burns only. The majority of our burn patients are transferred to Loyola University Medical Center with or without concomitant trauma. Pediatric burn patients are transferred to Comer Children's Hospital. Attached you will find our unit-based reference.

5. **BLOOD BANK**- Attached is the current Northlake campus Management and Storage of the Blood Supply policy in addition to the daily inventory summary for July 31, 2014. Currently the daily platelet count is kept at two units minimum. Should additional blood products be needed, we are supported by our sister campus, Methodist Southlake located 13 miles away.

6. **CALL SCHEDULES**- Attached you will find the July and August general call schedules for both Methodist campuses to ensure the committee that there is not an overlap in coverage. There was a scheduling oversight on July 17th and Dr. Rutland covered call at Northlake that day. The surgeons cover one campus at a time and the surgical group in question does NOT take call at the Northlake campus.



Northlake Campus
600 Grant Street
Gary, Indiana 46402

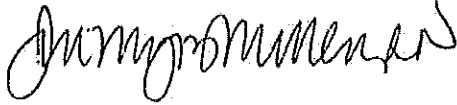
Midlake Campus
2269 West 25th Avenue
Gary, Indiana 46404

Southlake Campus
8701 Broadway
Merrillville, Indiana 46410

7. **POLICY SIGNATURES**- Previously submitted trauma policies have been updated with names and signature lines and are attached. Policies not owned by trauma services have not been updated, however, a summary of the policy approval process is attached to address any concerns the committee may have.
8. **RESOLUTION LETTERS**-Committee recommendation regarding format of resolution letters is noted and will be reformatted going forward. Orthopedic resolution letter has been amended at this time.

Feel free to contact me with any further questions.

Respectfully Submitted,



Jennifer Mullen, RN
Trauma Program Coordinator
Methodist Hospital



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8701 Broadway
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JULY SURGEON RESPONSE TIMES

DATE	LEVEL	MOI	SX NAME	ALERT TIME	SX PAGE TIME	SX Response	PATIENT ARRIVAL TIME	SX ARRIVAL TIME	Arrival Time
7/2/2014	TA	GSW	Rutland	0347	0347	0347	0409	0405	-4
7/12/2014	TA	GSW	Farias	0403	0459	0459	0408 Upgraded to TA @0459	0627	88
7/15/2014	TA	Assault	Farias	2047	2105	2105	2053 Upgraded to TA @2105	0659	536
7/21/2014	TA	MVC	Nyongani	1810	1810	1810	1818	1815	-3
7/21/2014	TA	MVC	Nyongani	2340	2352, 2359	0001	2343	0037	54
7/26/2014	TA	Motorcycle	Scott	1352	1354, 1358	1400	1405	1429	24

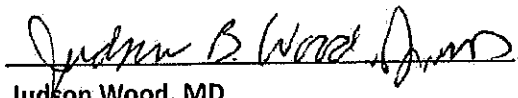
The Methodist Hospitals, Inc.

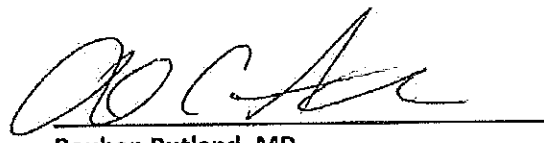
Orthopedic Surgery Medical Staff Resolution

The Orthopedic Medical Staff of Methodist Hospitals, Inc. recognizes both the community's need of trauma care and the invaluable contribution that trauma care will afford, and confirms its commitment to provide the necessary resources to achieve and sustain Level III trauma designation at its Northlake Campus located in Gary, Indiana.

The orthopedic surgeons are committed to providing care for the injured patient by ensuring an orthopedic surgeon is on call and promptly available twenty-four (24) hours per day. Additionally, active participation in both the Trauma Program Performance Improvement and Operative and Trauma Service Peer Review Committees are essential and attendance is required at least fifty percent of the time.




Judson Wood, MD
Orthopedic Surgery Trauma Liaison
Methodist Hospitals


Reuben Rutland, MD
Trauma Medical Director
Methodist Hospitals

Northlake Campus
600 Grant Street
Gary, Indiana 46402

Midlake Campus
2269 West 25th Avenue
Gary, Indiana 46404

Southlake Campus
8701 Broadway
Merrillville, Indiana 46410

NLC TRANSFER AGREEMENTS



BURNS	FACILITY	TRANSFER PROCESS	NOTES
Adult / Pediatric	Stroger Medical Center	Burn Resident Pager (312)-760-0789	Burns <u>OR</u> Burns with concomitant trauma
Adult / Pediatric	Loyola University Medical Center	Burn Center (708) 216-3988	Burns <u>OR</u> Burns with concomitant trauma
Adult / Pediatric	University of Chicago	Transfer Center (773) 834-4782	PEDS-Burns <u>OR</u> Burns w/ concomitant Trauma ADULTS-Burns only-NO concomitant trauma
Adult/Pediatric	St. Joseph (Fort Wayne)	Burn Center (260) 425-3570	Burns only-NO concomitant trauma

TRAUMA	FACILITY	TRANSFER PROCESS	NOTES
Adult / Pediatric	Loyola University Medical Center	Transfer Line (708) 216-5862	*** Cloud Capability effective 2/17/2014*** For Transfers or Remote Consults
Adult/Pediatric	IU Health	Transfer Center (877) 247-1177	
Adult/Pediatric	Memorial of South Bend	Transfer Line (866)-262-4247	Level II center
Adult	Advocate Christ Medical Center	Transfer Center (708) 684-5221	
Adult	Northwestern Memorial Hospital	External Transfer Line (312) 926-3321	
Pediatric	Comer Children's Hospital	Transfer Center (773) 834-4782	

Updated 2/5/2014

JD



PROCEDURE Subject: Management and Storage of the Blood Supply (NLC)		PROCEDURE NO.: LAB-BB_136
ORIGINAL DATE: 01/25/1995	SUPERSEDES: 12/2007	PAGE: 1 of 4

I. PURPOSE:

It is the responsibility of all Blood Bank personnel to ensure maximum utilization and minimum wastage of blood and blood products kept in the Blood Bank inventory. There are two keys to effective inventory management. The first is to establish hospital stock levels. The ideal stock level provides an adequate supply of blood for routine and emergency situations, minimizing outdating. The second is inventory rotation. The stock must be rotated so that the oldest units are used first. There must be an attempt to maintain maximum availability of blood and blood products with minimum amount of wastage.

See also: LAB-BB_004
LAB-BB_134

II. DEFINITIONS:

None

III. PROCEDURE:

<u>Responsible person</u>	<u>Action</u>
Blood Bank Technicians	

STORAGE:

RED CELLS

Storage of red cells will be in one of five areas of the refrigerator depending on the status of the unit. The red cells will be maintained between 1 and 6 degrees. Alarms will activate if the temperature reaches a low of 1.5-2.0°C or a high of 5.0-5.5°C. This will allow time for proper action to be taken before the red cells reach unacceptable temperatures. Alarms will be tested quarterly. See LAB-BB_134 for instructions for testing alarms.

1. **Quarantined:** The quarantined area of the refrigerator consists of unprocessed units of blood in addition to units that have been judged unsuitable for transfusion. Unprocessed blood units are those units that have been received from the blood center but have not yet been retyped. Blood

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will arrive in a plastic bag and will remain in the plastic bag until the blood unit has been retyped and suitable for placement on the available shelf. Quarantined blood that is unsuitable for transfusion will be placed in a clear plastic bag that has been clearly marked "QUARANTINED". These are units that have failed the visual inspection, are labeled incorrectly, have a positive DAT, etc. A variance report should be completed for each quarantined unit placed on this shelf. These units will ultimately be returned to the blood center if the blood center requests return. All blood units in Quarantine are to have the status of "Quarantine" in the laboratory computer. This function will not allow units to be used. If the blood product is requested for return to the blood center, the blood unit will again go from the "Quarantine" status to the "Ship Out" status. Proper trailing of the blood product is required.

Available: These are units that have been retyped and are available for crossmatching. The "AVAILABLE" shelves are arranged according to blood type and by expiration date, with the shortest dated units placed toward the front.

Allocated: These units have been crossmatched and "tagged" for transfusion. The "ALLOCATED" shelves are arranged according to blood type of the unit.

Autologous/Directed Donations: These units will be stored on the shelf labeled "AUTOLOGOUS/DIRECTED". Continuous monitoring of Pre-Admission patients will ensure that these units are assigned by the Medical Record Number before the patient is admitted for surgery.

Antigen Typed: These units have been antigen typed. These units may be used for a patient that requires a unit of blood that is negative for a specific antigen.

RED CELL STOCK LEVELS:

At the present time, the following amounts of blood should be used as a guide to inventory control. These numbers will vary according to the number and severity of the current hospital census.

Northlake:

O POS 30	O NEG 12
A POS 20	A NEG 8
B POS 12	B NEG 4

FRESH FROZEN PLASMA AND CRYOPRECIPITATE:

FFP and cryoprecipitate will be maintained at temperatures less than or equal to -18°C. The alarm will activate at -19°C to allow time for proper action to be taken before components reach unacceptable temperatures. An alarm check will be performed quarterly. See LAB-BB_134 for instructions on alarm testing.

Stock levels shall be maintained at 10 units of each ABO group of FFP. Cryoprecipitate stock a minimum of 5 random units of type A and type B and one fine pooled unit of type A and type B. (Five pooled cryoprecipitate is not orderable STAT.)

PLATELETS:

Platelets shall be maintained at 20-24°C. The incubator alarm will activate between 20.5-23.5°C. See LAB-BB_134 for instruction on alarm testing.

REQUESTING/RETURNING BLOOD TO AMERICAN RED CROSS:

American Red Cross in Fort Wayne is the distribution center serving Northwest Indiana and Ohio region. Call this location for routine or stat requests for RBC'S, FFP, Platelets, and Cryoprecipitate 24 hours a day. When requesting irradiated or antigen typed blood products, call the Reference Laboratory.

NOTE: Occasionally, products are not available from the American Red Cross. Look to other hospitals or Heartland Blood Centers to obtain the necessary products.

DAILY INVENTORY CONTROL:

Daily laboratory computer inventory summary shall be pulled and verified for all blood units. Plasma inventory shall be pulled once a week and verified.

NOTE:

The status of all blood components must be updated in the laboratory computer system. Place short date stickers on units that will outdate within the next 7 days. Resolve inventory discrepancies immediately.

IV. REFERENCE:

AABB Technical Manual
AABB Standards for Blood Banks and Transfusion Services

V. DOCUMENT INFORMATION

A. Prepared by

<u>Dept. & Title</u>	<u>Date</u>
Transfusion Services Supervisor	7/2011

B. Review and Renewal Requirements

This procedure will be reviewed every year and as required by change of law, practice or standard.

C. Review / Revision History

Reviewed on: 6/2010,12/2012, 9/2013

Revised on: 12/2007, 7/2011

D. Approvals

1. This Procedure has been reviewed and approved by the Vice President(s) of the Service Group(s):

<u>Vice President(s)</u>	<u>Date</u>
Operations	9/2013

2. This Procedure has been reviewed and/or approved by the following committee(s):

<u>Committee(s)</u>	<u>Date</u>
N/A	

3. This Procedure has been reviewed and approved by the following Medical Director and Laboratory Director

<u>Medical/Laboratory Directors</u>	<u>Date</u>
L. Teresa Vazquez, M.D. Medical Director of Laboratory Services Mushtaq Ahmed, Director of Laboratory Services	9/2013

07/31/2014
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METHODIST HOSPITALS, INC.

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BLOOD BANK - INVENTORY SUMMARY
For Hospital MHG

NML:NL BLOOD BANK

COMPONENT GROUP: CRYO GRP

ABO/RH	UNPROCESSED	UNPROCESSED DONATION	AVAILABLE	ALLOCATED	TOTAL
E3587 CRY 5P					
A POS	0	0	1	0	1
B POS	0	0	1	0	1

TOTAL	0	0	2	0	2
DERIVATIVE UNITS	0	0	0	0	0
=====					
E5165 CRYO					
A POS	0	0	5	0	5
B POS	0	0	3	0	3
O POS	0	0	2	0	2

TOTAL	0	0	10	0	10
DERIVATIVE UNITS	0	0	0	0	0
=====					
*** TOTAL FOR *** CRYO GRP					
A POS	0	0	6	0	6
B POS	0	0	4	0	4
O POS	0	0	2	0	2

TOTAL	0	0	12	0	12
DERIVATIVE UNITS	0	0	0	0	0

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METHODIST HOSPITALS, INC.

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BLOOD BANK - INVENTORY SUMMARY
For Hospital MHG

COMPONENT GROUP: PLASMA GRP

ABO/RH	UNPROCESSED	UNPROCESSED DONATION	AVAILABLE	ALLOCATED	TOTAL
PLASMA E0869					
AB NEG	0	0	1	0	1
TOTAL	0	0	1	0	1
DERIVATIVE UNITS	0	0	0	0	0
=====					
E2555 PLASMA					
A POS	0	0	3	0	3
AB NEG	0	0	5	0	5
B NEG	0	0	1	0	1
B POS	0	0	5	0	5
O NEG	0	0	4	0	4
O POS	0	0	4	0	4
TOTAL	0	0	22	0	22
DERIVATIVE UNITS	0	0	0	0	0
=====					
E2587 PLASMA					
O NEG	0	0	2	0	2
TOTAL	0	0	2	0	2
DERIVATIVE UNITS	0	0	0	0	0
=====					
E2619 PLASMA					
A NEG	0	0	3	0	3
A POS	0	0	9	0	9
AB POS	0	0	6	0	6
B NEG	0	0	4	0	4
B POS	0	0	5	0	5
O NEG	0	0	3	0	3
O POS	0	0	8	0	8
TOTAL	0	0	38	0	38
DERIVATIVE UNITS	0	0	0	0	0
=====					
*** TOTAL FOR *** PLASMA GRP					
A NEG	0	0	3	0	3
A POS	0	0	12	0	12
AB NEG	0	0	6	0	6
AB POS	0	0	6	0	6
B NEG	0	0	5	0	5
B POS	0	0	10	0	10
O NEG	0	0	9	0	9
O POS	0	0	12	0	12
TOTAL	0	0	63	0	63

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METHODIST HOSPITALS, INC.

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BLOOD BANK - INVENTORY SUMMARY
For Hospital MHG

COMPONENT GROUP: PLATELET GRP

ABO/RH	UNPROCESSED	UNPROCESSED DONATION	AVAILABLE	ALLOCATED	TOTAL
E3087 LSDP					
AB POS	0	0	1	0	1
B POS	0	0	0	1	1

TOTAL	0	0	1	1	2
DERIVATIVE UNITS	0	0	0	0	0
=====					
E3088 LSDP					
B NEG	0	0	0	1	1

TOTAL	0	0	0	1	1
DERIVATIVE UNITS	0	0	0	0	0
=====					
*** TOTAL FOR *** PLATELET GRP					
AB POS	0	0	1	0	1
B NEG	0	0	0	1	1
B POS	0	0	0	1	1

TOTAL	0	0	1	2	3
DERIVATIVE UNITS	0	0	0	0	0

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METHODIST HOSPITALS, INC.

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BLOOD BANK - INVENTORY SUMMARY
For Hospital MHG

COMPONENT GROUP: RED CELL GRP

ABO/RH	UNPROCESSED	UNPROCESSED DONATION	AVAILABLE	ALLOCATED	TOTAL
LRIRPC E0224					
O NEG	0	0	2	0	2

TOTAL	0	0	2	0	2
DERIVATIVE UNITS	0	0	0	0	0
=====					
E0336 LR PC					
A NEG	0	0	3	0	3
A POS	0	0	7	2	9
B NEG	0	0	2	0	2
B POS	0	0	3	2	5
O NEG	0	0	5	3	8
O POS	0	0	9	0	9

TOTAL	0	0	29	7	36
DERIVATIVE UNITS	0	0	0	0	0
=====					
E0382 LR PC					
A NEG	0	0	3	0	3
A POS	0	0	4	0	4
B NEG	0	0	1	0	1
B POS	0	0	4	1	5
O POS	0	0	1	9	10

TOTAL	0	0	13	10	23
DERIVATIVE UNITS	0	0	0	0	0
=====					
E0685 LR PC					
A NEG	0	0	1	0	1
O NEG	0	0	2	0	2

TOTAL	0	0	3	0	3
DERIVATIVE UNITS	0	0	0	0	0
=====					
E0686 LR PC					
A NEG	0	0	1	0	1
B NEG	0	0	1	0	1
O NEG	0	0	1	0	1

TOTAL	0	0	3	0	3
DERIVATIVE UNITS	0	0	0	0	0
=====					
*** TOTAL FOR *** RED CELL GRP					
A NEG	0	0	8	0	8
A POS	0	0	11	2	13
B NEG	0	0	4	0	4

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METHODIST HOSPITALS, INC.

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BLOOD BANK - INVENTORY SUMMARY
For Hospital MHG

B POS	0	0	7	3	10
O NEG	0	0	10	3	13
O POS	0	0	10	9	19
<hr/>					
TOTAL	0	0	50	17	67
DERIVATIVE UNITS	0	0	0	0	0

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July

METHODIST HOSPITALS / EMERGENCY DEPARTMENT TRAUMA / NORTHLAKE CAMPUS

Sun	Mon	Tue	Wed	Thu	Fri	Sat
6/7/14 REVISED: 6/24/14, 6/30, 7/10, 7/15		1 ATIF RUTLAND	2 SCOTT	3 NYONGANI	4 RUTLAND	5 RUTLAND
6 RUTLAND	7 FARIAS	8 SCOTT	9 NYONGANI	10 ATIF	11 FARIAS	12 FARIAS
13 FARIAS	14 SCOTT	15 RUTLAND FARIAS	16 FARIAS	17 NYONGANI ATIF	18 ATIF	19 ATIF
20 ATIF	21 NYONGANI	22 SCOTT	23 RUTLAND	24 FARIAS	25 SCOTT	26 SCOTT
27 SCOTT	28 ATIF NYONGANI	29 NYONGANI	30 RUTLAND	31 NYONGANI		

2014

PLEASE REVIEW THIS CALL SCHEDULE CAREFULLY. IF YOU ARE UNABLE TO TAKE YOUR SCHEDULED ER CALL, IT IS YOUR RESPONSIBILITY TO FIND COVERAGE AND TO INFORM THE APPROPRIATE EMERGENCY DEPARTMENTS AT NLC @ 886-4710; SLC @ 738-5510 and Physician Services @ 738-5891 TO MAKE APPROPRIATE CHANGES.

Division Chief Approval: _____ Date: _____

July

METHODIST HOSPITALS / EMERGENCY DEPARTMENT GENERAL SURGERY / SOUTHLAKE CAMPUS

* *

Sun	Mon	Tue	Wed	Thu	Fri	Sat
6/17 REVISED: 6/24/14, 2nd, 7/2		1 NYONGANI	2 INDIANA SURGICAL ASSOCIATES 947-1910	3 SCOTT	4 ATIF SCOTT	5 SCOTT
6 INDIANA SURGICAL ASSOCIATES 947-1910	7 NYONGANI	8 RUTLAND	9 SCOTT	10 NYONGANI	11 RUTLAND	12 INDIANA SURGICAL ASSOCIATES 947-1910
13 NYONGANI	14 INDIANA SURGICAL ASSOCIATES 947-1910	15 SCOTT	16 RUTLAND	17 ATIF	18 INDIANA SURGICAL ASSOCIATES 947-1910	19 NYONGANI
20 RUTLAND	21 SCOTT ATIF	22 INDIANA SURGICAL ASSOCIATES 947-1910	23 ATIF	24 RUTLAND	25 NYONGANI	26 RUTLAND
27 INDIANA SURGICAL ASSOCIATES 947-1910	28 RUTLAND	29 ATIF	30 INDIANA SURGICAL ASSOCIATES 947-1910	31 SCOTT		

PLEASE REVIEW THIS CALL SCHEDULE CAREFULLY. IF YOU ARE UNABLE TO TAKE YOUR SCHEDULED ER CALL, IT IS YOUR RESPONSIBILITY TO FIND COVERAGE AND TO INFORM THE APPROPRIATE EMERGENCY DEPARTMENTS AT MLC @ 886-4710; SLC @ 738-5510 and Physician Services @ 738-5891 TO MAKE APPROPRIATE CHANGES.

Division Chief Approval: _____ Date: _____

2014

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August

METHODIST HOSPITALS / EMERGENCY DEPARTMENT TRAUMA / NORTHLAKE CAMPUS

~~XXXXXX~~

Sun	Mon	Tue	Wed	Thu	Fri	Sat
6/25/14, AS OF 7/28					1 NYONGANI	2 ATIF
3 NYONGANI	4 SCOTT	5 ATIF	6 RUTLAND	7 RUTLAND	8 SCOTT	9 SCOTT
10 SCOTT	11 ATIF	12 RUTLAND	13 NYONGANI	14 SCOTT	15 ATIF	16 NYONGANI
17 RUTLAND	18 NYONGANI	19 SCOTT	20 RUTLAND	21 ATIF	22 RUTLAND	23 RUTLAND
24 RUTLAND	25 ATIF	26 NYONGANI	27 RUTLAND	28 SCOTT	29 ATIF	30 ATIF
31 ATIF						

PLEASE REVIEW THIS CALL SCHEDULE CAREFULLY. IF YOU ARE UNABLE TO TAKE YOUR SCHEDULED ER CALL, IT IS YOUR RESPONSIBILITY TO FIND COVERAGE AND TO INFORM THE APPROPRIATE EMERGENCY DEPARTMENTS AT NLC @ 886-4710; SLC @ 738-5510 and Physician Services @ 738-5891 TO MAKE APPROPRIATE CHANGES.

Division Chief Approval: _____ Date: _____

2014

17A

August

METHODIST HOSPITALS / EMERGENCY DEPARTMENT GENERAL SURGERY / SOUTHLAKE CAMPUS

Sun	Mon	Tue	Wed	Thu	Fri	Sat
6/25/14					1 INDIANA SURGICAL ASSOCIATES 947-1910	2 SCOTT
3 ATIF	4 INDIANA SURGICAL ASSOCIATES 947-1910	5 RUTLAND	6 SCOTT	7 INDIANA SURGICAL ASSOCIATES 947-1910	8 ATIF	9 NYONGANI
10 RUTLAND	11 SCOTT	12 ATIF	13 INDIANA SURGICAL ASSOCIATES 947-1910	14 NYONGANI	15 RUTLAND	16 SCOTT
17 ATIF	18 RUTLAND	19 INDIANA SURGICAL ASSOCIATES 947-1910	20 NYONGANI	21 SCOTT	22 INDIANA SURGICAL ASSOCIATES 947-1910	23 ATIF
24 NYONGANI	25 INDIANA SURGICAL ASSOCIATES 947-1910	26 RUTLAND	27 SCOTT	28 ATIF	29 NYONGANI	30 RUTLAND
31 INDIANA SURGICAL ASSOCIATES 947-1910						

PLEASE REVIEW THIS CALL SCHEDULE CAREFULLY. IF YOU ARE UNABLE TO TAKE YOUR SCHEDULED ER CALL, IT IS YOUR RESPONSIBILITY TO FIND COVERAGE AND TO INFORM THE APPROPRIATE EMERGENCY DEPARTMENTS AT NLC @ 886-4710; SLC @ 738-5510 and Physician Services @ 738-5891 TO MAKE APPROPRIATE CHANGES.

Division Chief Approval: _____ Date: _____

2014



POLICY Subject: Requirements and Responsibilities of Trauma Medical Director		POLICY NO.: TR_01
ORIGINAL DATE: October 20, 2013	SUPERSEDES: n/a	PAGE: 1

Key Words: Trauma, Medical Director, Authority, Responsibilities

Applies to: Inpatient: _ Outpatient: _ Provider: _ All: X

Video: _

I. POLICY:

The Trauma Medical Director (TMD) leads the multidisciplinary activities of the trauma program at Methodist Hospital's Northlake Campus and is responsible for the organizational integrity of the program. The Trauma Medical Director works collaboratively with the Trauma Program Coordinator (TPC) to assure compliance with both the verification requirements of American College of Surgeons, as outlined in *Resources for the Optimal Care of the Injured Patient, 2006*, and Indiana Statewide Trauma System requirements.

A. Requirements of the Trauma Medical Director:

1. Must be a board-certified or board eligible general surgeon or an American College of Surgeons Fellow.
2. Must participate in trauma call.
3. Must be current in Advanced Trauma Life Support (ATLS).
4. Must participate in regional and/or national trauma organizations.
5. Must oversee the Trauma Program Performance Committee and attend all meetings.
6. Must be actively involved in pre-hospital personnel training, the PIPS process, and the development of trauma components of Emergency Medical Services.
7. Trauma Medical Director will serve as the Intensive Care Co-Director, working with the ICU Medical Director, overseeing all aspects of trauma medical care.

B. Responsibilities of the Trauma Medical Director:

1. Has oversight authority to manage all aspects of trauma care and to correct deficiencies.
2. Has the authority to set qualifications and to determine each general surgeon's ability to participate on the trauma team.
3. Has the authority to determine trauma service privileges of the on-call panel and may exclude trauma team member who do not meet specified criteria. Appointment or removal of personnel from the Trauma Service is done by the Trauma Medical Director in accordance with Medical Staff Bylaws.
 - i. Issues unresolved by the Trauma Medical Director through Methodist Hospital's Northlake Campus organizational structure, are addressed by the Chief Medical Officer, or the Chief Executive Officer (CEO). This mechanism includes direct consultation with the affected service,

including but not limited to, physician consultants or departments within the hospital.

4. Monitors trauma patient care on an ongoing basis through the Trauma Program Performance Committee.
 5. Will lead the development of and approve before implementation, trauma care guidelines for the following areas:
 - a. Emergency Department
 - b. ICU
 - c. Operating Room and Post-Anesthesia Care Unit
 - d. Adult Medical Surgical Units
 - e. Emergency Medical Services
- C. The Trauma Program Coordinator performs under the direction of the Trauma Medical Director and Director of Emergency Services and interacts with all departments on behalf of the Medical Director when indicated.

II. DEFINITIONS:

n/a

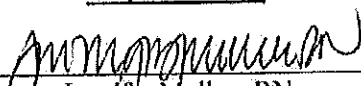
III. REFERENCE:

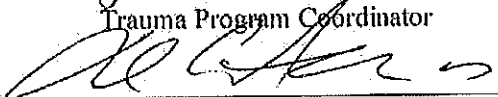
Resources for Optimal Care of the Injured Patient, Committee on Trauma, American College of Surgeons, 2006

IV. DOCUMENT INFORMATION

A. Prepared by

Dept. & Title


Jennifer Mullen, RN
Trauma Program Coordinator


Reuben Rutland, MD
Trauma Medical Director

B. Review and Renewal Requirements

This policy will be reviewed annually and as required by change of law, practice or standard.

C. Review / Revision History

Reviewed on: "Type Date (mm/yyyy)."
Revised on: "Type Date (mm/yyyy)."

D. Approvals

1. This Policy & Procedure has been reviewed and approved by the Vice President(s) of the Service Group(s):

Vice President(s)

Date



Michele Major, RN
Chief Nursing Officer

2/13/2014

2. This Policy & Procedure has been reviewed and/or approved by the following committee(s):

Committee(s)

Date

Trauma Program Performance Improvement Committee
LPIC
Medical Council

10/29/2013
12/03/2013
1/28/2014

21A



POLICY AND PROCEDURE		POLICY NO.:
Subject: Trauma Criteria-NORTHLAKE CAMPUS		TR_03
ORIGINAL DATE: 04/1989	SUPERSEDES: NEW	PAGE: 1

Key Words: Trauma, Criteria, Activation, Stand-by, Northlake

Applies to: Inpatient: _ Outpatient: _ Provider: _ All: X

Video: _

I. POLICY:

Trauma Criteria is required by the American College of Surgeons and is intended to identify patients at greatest risk for life and/or limb threatening injury. When a trauma patient is identified, the appropriate category will be immediately activated-either from the field or at the point of first identification.

The following activation criteria are mandatory and in conjunction with a traumatic injury.

- A. **TRAUMA ACTIVATION** –The general surgeon on-call will be contacted immediately and is required to be present within thirty (30) minutes of patient arrival. Response times will be continuously monitored and reviewed at the Trauma Program Performance Committee.
 - a. Intubated patient or patient with airway/respiratory compromise attributed to traumatic injury
 - b. Hemodynamic Compromise- $SBP \leq 90$ at any time or age appropriate hypotension as outlined below:
 - i. Newborn to 1 month: $SBP < 60$
 - ii. 1 month -1 year: $SBP < 70$
 - iii. > 1 year: $SBP < 70 + (2 \times \text{age})$
 - c. Traumatic Arrest
 - d. $GCS \leq 8$ with mechanism attributed to trauma
 - e. All penetrating injuries to head, neck, chest, abdomen, or back
 - f. Transferred-in patients receiving blood products to maintain vital signs due to traumatic injury
 - g. ED Physician discretion
- B. **TRAUMA STAND-BY** – The Emergency Department (ED) Physician will evaluate, treat, and discharge patient or may call surgeon after initial evaluation for further evaluation and/or admission.
 - a. Falls > 20 feet (two stories) (Pediatric - $3 \times$ times body length)
 - b. Penetrating injuries above the elbow or knee
 - c. Electrical, chemical, or thermal burns $\geq 20\%$ of total body surface area
 - d. High-risk motor vehicle collisions:
 - i. Significant intrusion into passenger compartment
 - ii. Ejection
 - iii. Death in same vehicle
 - iv. Extrication
 - v. Rollover
 - e. Auto vs. pedestrian or bicyclist
 - f. Motorcycle crash

- g. Open or depressed skull fracture
- h. Amputation above wrist or ankle
- i. Two or more long bone fractures (humerus/femur, femur/femur, etc.)
- j. EMS provider discretion
- k. ED Physician discretion

C. **NON-MANDATORY CRITERIA**- When the previous criteria have not been met and in conjunction with *traumatic injuries*, Trauma Stand-by may be initiated at the provider's discretion with the following patients:

- i. <5 or >55
- ii. > 20 weeks pregnant
- iii. Clotting disorder or currently taking anticoagulants
- iv. Inhalation injury

NOTE: If at any point during the resuscitation of a **TRAUMA STAND-BY** the patient becomes unstable and meets **TRAUMA ACTIVATION** criteria, the patient will be upgraded as such and the trauma surgeon immediately called.

D. **TRAUMA CONSULT** - Any trauma patient who does not meet Trauma Activation or Trauma Stand-by criteria but still has an injury that requires the evaluation of a general or specialty evaluation.

II. DEFINITIONS:

- A. **TRAUMA ACTIVATION**-identifies patients at highest risk for life or limb threatening injuries and elicits a full trauma team response.
- B. **TRAUMA STAND-BY**- identifies patients at high risk for significant injury due to mechanism of injury and elicits a partial trauma team response.

III. PROCEDURE:

<u>Responsible person</u>	<u>Action</u>
Emergency Department MD or RN	Upon identification of a patient meeting trauma criteria, either from the field or upon presentation to the Emergency Department (ED), the appropriate trauma category will be determined and initiated.
Health Unit Partner (HUP)	<ol style="list-style-type: none"> 1. The Health Unit Partner will dial 22 and provide the operator with the following information: <ol style="list-style-type: none"> a. Trauma Activation or Trauma Stand-By b. Number of patients-Adult or Pediatric 2. For <u>all Trauma Activations</u> <i>the general surgeon on call is immediately paged .</i>
Hospital Operator	<p>The hospital operator announces the following information overhead, repeating it twice:</p> <ol style="list-style-type: none"> 1. Level of activation 2. Number of patients

<p><u>Trauma Team Member Response:</u></p> <p>TRAUMA ACTIVATION</p>	<ol style="list-style-type: none"> 1. General Surgeon (should be physically present within thirty (30) minutes of patient arrival) 2. Emergency Department RN x 2 3. Emergency Department Attending MD (and resident when present) 4. ED Technician 5. Respiratory Therapist- one therapist to respond immediately to trauma bay with ventilator 6. Radiology Technologist –responds immediately to trauma bay 7. CT Technologist- clears CT scanner, responds to trauma bay for patient status, then prepares for scanner patient if necessary. 8. Chaplain-the covering chaplain will be paged by the hospital operator and will respond to the ED 9. OR Desk-to call ED Charge RN for patient status and potential need for OR intervention when in house 10. House Manager (after hours & weekends/holidays)-to call ED charge RN or respond to trauma bay to evaluate need for OR intervention or bed placement. 11. Blood Bank personnel – will immediately respond to trauma bay with blood cooler 12. Anesthesia – to be notified by either ED MD or House Manager when need for OR intervention is identified 13. ICU Charge RN-to call ED Charge RN for patient status and need for potential bed placement 14. Security- Responds immediately for all Trauma Activations by posting outside the Trauma bay doors.
<p>TRAUMA STAND-BY</p>	<ol style="list-style-type: none"> 1. Emergency Department RN x 2 2. Emergency Department Attending MD (and resident when present) 3. ED Technician 4. Radiology Technologist –responds immediately to trauma bay 5. CT Technologist-clears CT scanner, responds to trauma bay for patient status, then prepares for scanner patient if necessary.

IV. REFERENCE:


2011,U.S Department of Health and Human Services, Center for Disease Control and Prevention, National Center for Injury Prevention and Control, Division of Injury Response, Guidelines for Field Triage of Injured Patients.

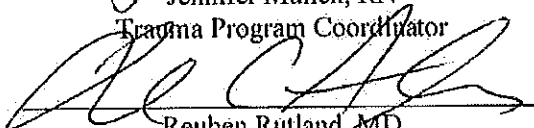
2006, Resources for Optimal care of the Injured Patient 2006, Committee on Trauma, American College of Surgeons

V. DOCUMENT INFORMATION

A. Prepared by

Dept. & Title


Jennifer Mullen, RN
Trauma Program Coordinator


Reuben Rutland, MD
Trauma Medical Director

B. Review and Renewal Requirements

This policy & procedure will be reviewed annually and as required by change of law, practice or standard.

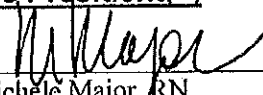
C. Review / Revision History

Reviewed on: 2/17/2014

Revised on: 2/17/2014

D. Approvals

1. This Policy & Procedure has been reviewed and approved by the Vice President(s) of the Service Group(s):

<u>Vice President(s)</u>	<u>Date</u>
 Michele Major, RN Chief Nursing Officer	3/27/2014

2. This Policy & Procedure has been reviewed and/or approved by the following committee(s):

<u>Committee(s)</u>	<u>Date</u>
Shared Governance	3/26/2014
Trauma Program Performance Improvement Committee	3/6/2014
LPIC	3/4/2014
Medical Council	3/20/2014



POLICY AND PROCEDURE Subject: Trauma Diversion		POLICY NO.: TR_05
ORIGINAL DATE: October 23, 2013	SUPERSEDES: Original	PAGE: 1

Key Words: Trauma, Diversion, Bypass

Applies to: Inpatient: _ Outpatient: _ Provider: _ All: X

Video: _

I. POLICY:

- A. To provide a guideline for Trauma diversion due to resource limitations in accordance with the American College of Surgeons, Committee on Trauma. Trauma diversion of ambulance traffic is to be avoided and instituted only as a last resort. Methodist Hospital is committed to instituting bypass no more than 5% of the time.

1. The Trauma Medical Director must be involved in all trauma diversion decision making.
2. All instances of trauma diversion will be reviewed by the Trauma Program Performance Improvement Committee.
3. Diversion will be re-evaluated at two hour intervals.

B. Acceptable circumstances in which to declare trauma diversion:

1. Any internal disaster (ie. Fire, bomb, electrical failure, etc.) which directly impacts the Emergency Department (ED), Computed Tomography (CT), or Operating Rooms.
2. Lack of Operating Room availability because all staffed operating rooms are in use or fully implemented with on-call teams and at least one or more of the procedures is an operative trauma case.
3. All Computed Tomography (CT) scanners are inoperable.
4. No available monitored beds in-house or in the ED.
5. The ED's volume/acuity of patients has overwhelmed available Emergency Department resources of space, equipment, or staffing.

C. Exceptions to trauma diversion:

1. Any patient in need of an airway or other life-saving intervention must be transported to our facility.
2. Walk-in patients during diversion must be medically screened and triaged appropriately.

II. DEFINITIONS:

Diversion-The process of diverting ambulance traffic in cases where resources are not sufficient to meet potential or real needs.

III. PROCEDURE:

<u>Responsible person</u>	<u>Action</u>
<u>IN THE EVENT OF PLANNED MAINTENANCE/REPAIR</u>	<ol style="list-style-type: none"> 1. The Facilities Director will give advance notice of maintenance/repair and approximate length of time required to complete to the following people: <ol style="list-style-type: none"> a. Appropriate Department Manager and Director (ie. OR/CT) b. Emergency Department Manager c. Emergency Department Director d. Clinical administrator on call e. Administrator on call f. House Manager scheduled for affected shift (s) g. EMS Coordinator h. Trauma Program Coordinator i. Trauma Medical Director 2. A collaborative and coordinated decision will be made regarding necessity and appropriateness of bypass and persons noted above will be responsible for communicating bypass to their respective departments. 3. The ED Charge RN/designee will notify Hospitals and EMS providers listed on Methodist Hospital Diversion Communication Log at the following intervals: <ol style="list-style-type: none"> a. Upon onset of Diversion. b. Update at two hour intervals. c. Upon discontinuation of diversion.
<u>IN THE EVENT OF UNPLANNED OR, CT, MONITORED BED UNAVAILABILITY, OR INTERNAL DISASTER</u>	<ol style="list-style-type: none"> 1. The ED Attending will determine if there is an acceptable circumstance to declare trauma diversion. 2. The Trauma Medical Director (TMD) or designee will be contacted regarding situation and the TMD will make the decision whether trauma diversion is authorized. 3. The ED Charge RN will contact the following: <ol style="list-style-type: none"> a. House Manager b. ED Manager c. EMS Coordinator d. Trauma Program Coordinator 3. The Clinical Administrator on-call will be apprised of the circumstances and notify the Administrator on-call. 4. The ED Charge RN/designee will notify Hospitals and EMS providers listed on Methodist Hospital Diversion Communication

	Log at the following intervals: a. Upon onset of Diversion. b. Update at two hour intervals c. Upon discontinuation of diversion.
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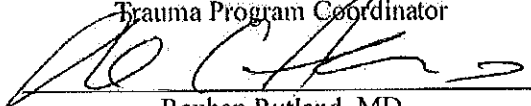
IV. REFERENCE:

"2006, Resources for the Optimal Care of the Injured Patient 2006, Committee on Trauma, American College of Surgeons"

V. DOCUMENT INFORMATION

A. Prepared by

Dept. & Title


 Jennifer Mullen, RN
 Trauma Program Coordinator

 Reuben Rutland, MD
 Trauma Medical Director

B. Review and Renewal Requirements

This policy will be reviewed annually and as required by change of law, practice or standard.

C. Review / Revision History

Reviewed on: n/a

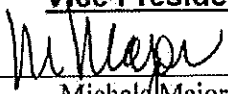
Revised on: n/a

D. Approvals

1. This Policy & Procedure has been reviewed and approved by the Vice President(s) of the Service Group(s):

Vice President(s)

Date


 Michele Major, RN
 Chief Nursing Officer

3/27/2014

2. This Policy & Procedure has been reviewed and/or approved by the following committee(s):

Committee(s)

Date

Shared Governance
 Trauma Program Performance Improvement Committee

3/26/2014

3/6/2014

LPIC
Medical Council

3/4/2014
3/20/2014

Methodist Hospital Diversion Communication Log

DATE / TIME OF INITIATION: _____ DATE / TIME DISCONTINUED: _____

REASON FOR BYPASS: ☐ FULL (closed to ALL EMS transports) ☐ ALS (closed to EMS ALS transports only) ☐ TRAUMA (closed to EMS TRAUMA transports only)

Call facilities below, identify yourself, request name of person speaking with, and notify type of bypass. Update every 2 hours and when off bypass.

HOSPITAL/EMS AGENCY NAME	NUMBER (SPEAK TO CHARGE RN)	NOTIFICATION TIME/INITIALS	CONTACT NAME	NOTIFICATION TIME/INITIALS	CONTACT NAME	NOTIFICATION TIME/INITIALS	CONTACT NAME
Methodist SLC	738-5510						
St. Anthony's-Crown Point	757-6310						
St. Mary's-Hobart	947-6200						
Porter Regional	219-983-8311						
Portage Community	219-759-5454						
Munster Community	836-4511						
St. Margaret's-South	864-2077						
St. Margaret's-North	933-2077						
St. Catherine's	392-7203						
Crown Point EMS	663-2121						
Gary Fire Department	881-5285						
Hobart EMS	942-5184						
Porter County/Portage	219-477-3170						
Superior	736-7400						
Prompt	838-4444						
Northwest	756-1367						
US Steel	888-4221						
Trauma Program Coordinator	cell # on file						
EMS Coordinator	cell # on file						
Trauma Medical Director	cell # on file						
House Manager (for affected campus only)	NLC-3902 SLC-7573						
ED Manager	cell # on file						



POLICY AND PROCEDURE		POLICY NO.:
Subject: Trauma Transfers		TR_06
ORIGINAL DATE: December 1, 2013	SUPERSEDES: Original	PAGE: 1

Key Words: Trauma, Transfer, EMTALA

Applies to: Inpatient: _ Outpatient: _ Provider: _ All: X

Video: _

I. POLICY:

- A. Patient transfer requirements are mandated by federal laws for the protection of the patient from unnecessary and potentially harmful transfers; therefore patients are not transferred arbitrarily. The transfer of an injured patient occurs when the level of care provided at a Level I or Level II Trauma Center is more appropriate to the patient's condition.
- B. Transfer from Methodist Hospital will be done in accordance with this policy and conducted with mutual agreement of the transferring and receiving hospital based upon transfer agreements.
- C. All trauma patient transfers will be evaluated for appropriateness and reviewed by the Trauma Program Performance Improvement Committee.
- D. The decision to transport will be based solely on the patients' needs and not the ability to pay.
- E. Trauma transfers must be prompt and every effort should be made to expedite the decision to transfer within thirty (30) minutes of patient arrival.
- F. Once the decision to transport is made, it will not be delayed by labs or diagnostic testing.
- G. No patient should be transferred without speaking to the appropriate surgical service on-call.
- H. No patient will be transferred without direct physician to physician contact.
- I. The following are injuries that should immediately activate emergency transfer procedures:
 1. Orthopedic Injuries
 - a. Pelvic fractures including: complex acetabular fractures, pelvic ring disruption, open pelvic injury, concomitant shock or evidence of ongoing hemorrhage.
 - b. Hand injuries with flexor/extensor injuries
 - c. Complex open comminuted long bone fractures
 - d. Fracture/dislocation with loss of distal pulses
 2. Burns
 - a. Partial thickness burns greater than 10% total body surface area (TBSA)
 - b. Burns involving the face, hands, feet, genitals, perineum, or major joints.

- c. Third degree burns
 - d. Electrical burns, including lightening injury
 - e. Chemical burns
 - f. Inhalation injury
 - g. Burn injury in patients with pre-existing medical disorders that could complicate management, prolong recovery, or affect mortality.
 - h. Any patient with burns and concomitant trauma (such as fractures) in which the burn injury poses the greatest risk of morbidity and mortality
 - i. Burned children
 - j. Burn injury in patients who will require special social, emotional, or rehabilitative intervention
3. General Surgery
- a. Vascular injury with threatened limb when no vascular coverage is available.
 - b. Complex poly-trauma at discretion of attending general surgeon.
4. Neurosurgery
- There is intermittent Neurosurgical coverage at Methodist Hospital and transfer agreements exist with Level I and II Trauma Centers for care of the patients with the following when coverage is not available:
- a. Intracranial hemorrhage
 - b. Spinal fractures with spinal cord injury
 - c. Cranial trauma
 - d. Complex craniofacial trauma
 - e. Penetrating cranial injury, including gunshot wounds or depressed skull fractures
5. Pediatrics
- a. Any child <15 years old with significant injury will be transferred to a Pediatric Trauma Center
6. OB-GYNE - at discretion of surgeon and OB/GYNE on call

II. DEFINITIONS:

None

III. PROCEDURE:

<u>Responsible person</u>	<u>Action</u>
Referring (ED) Physician/Designee	<ol style="list-style-type: none"> 1. The ED Physician/designee should contact the appropriate hospital to initiate the transfer process. The receiving referral center must confirm that the patient is accepted. Patients cannot be transferred without an accepting physician. 2. Once the patient is accepted, mode of transport is considered by the ED physician based on the patient's medical needs during transport and the need to minimize out-of-hospital transport time. 3. The Methodist Hospital ED physician is ultimately responsible for the decision regarding the appropriate mode of and arranging of transport. 4. If a ground ambulance is the indicated mode of transport, Methodist Hospital will contact the appropriately licensed ambulance service of its choice that is capable of providing the level of care required. 5. A copy of all medical records must be sent with the patient including: <ol style="list-style-type: none"> a. Physician notes b. Nursing notes c. Medication and fluid records d. Laboratory results e. Xray/CT imaging results (for receiving hospitals with Cloud

	capability-radiology should be contacted to transfer images digitally as well) f. Patient transfer form
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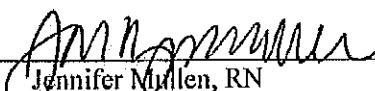
IV. REFERENCE:

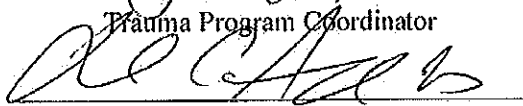
EMTALA, "2006, Resources for the Optimal Care of the Injured Patient 2006, Committee on Trauma, American College of Surgeons"

V. DOCUMENT INFORMATION

A. Prepared by

Dept. & Title


Jennifer Mullen, RN
Trauma Program Coordinator


Reuben Rutland, MD
Trauma Medical Director

B. Review and Renewal Requirements

This policy will be reviewed annually and as required by change of law, practice or standard.

C. Review / Revision History

Reviewed on: "Type Date (mm/yyyy)."


Revised on: "Type Date (mm/yyyy)."

D. Approvals

1. This Policy & Procedure has been reviewed and approved by the Vice President(s) of the Service Group(s):

Vice President(s)

Date


Michele Major, RN
Chief Nursing Officer

3/21/2014

2. This Policy & Procedure has been reviewed and/or approved by the following committee(s):

Committee(s)

Date

Shared Governance
Trauma Program Performance Improvement Committee
LPIC
Medical Council

3/26/2014
3/6/2014
3/4/2014
3/20/2014

Methodist Hospital Policy Review Process

Methodist's Hospital policy and procedure flow process requires all policies, whether new, reviewed or revised, go through the approval process. The owner of the policy is responsible for following the policy through the approval process. All participants involved in the development of a policy and procedure are noted on each document.

All policies and procedures will be completed as outlined below:

1. Hospital policies will be reviewed or revised annually at a minimum.
2. Policies requiring more frequent review or revision due to regulation, or changes in standards or practice will be addressed as needed.
3. All policies new, reviewed, or revised must go through the approval process. The approval process for all policies is as follows:
Nursing Shared Governance, Trauma Program Performance Improvement Committee, Leadership Performance Improvement Council, and Medical Council.
Once the appropriate committee (s) has (have) approved the policy, the Committee (s) is (are) listed under the approval section along with the date which the policy was approved. Final approval by the Chief Nursing Officer and/or Vice President and the date approved occurs once the policy has been reviewed by all respective committees.

The approval section of each policy outlines the above explained process which, per the Methodist's Hospital Quality Department, meets CMS, HFAP, and the Indiana State Board of Health standards.